INDIANA COMMISSION ON EXCELLENCE IN HEALTH CARE

Legislative Services Agency
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MEETING MINUTES[1]

Meeting Date:	**October 27, 2004**
Meeting Time:	**1:00 P.M.**
Meeting Place:	**State House, 200 W. Washington St., the Senate Chambers**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**3**

Members Present: **Sen. Patricia Miller, Chairperson; Sen. Gary Dillon; Sen. Allie Craycraft; Rep. Charlie Brown; Rep. Peggy Welch; Rep. Vaneta Becker; Rep. Timothy Brown; Amy Brown; Gregory Wilson; Walter J. Daly.**

Members Absent: **Sen. Earline Rogers; Michael Urban; Beverly Richards.**

Senator Miller (Chairperson) called the Indiana Commission on Excellence in Health Care to order at 1:05 p.m. A moment of silence was observed for former Senator Harold "Potch" Wheeler and his family.

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[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

The Chairperson commented that Indiana had mandated bariatric surgery coverage and now there are reports that the use of the surgery might be subject to abuses.

Randy L. Howard, M.D., Senior Medical Director, Anthem Blue Cross Blue Shield

Dr. Howard distributed information concerning obesity and bariatric surgery (Exhibit #1) and the BlueCross BlueShield of Tennessee Medical Policy Manual for Bariatric Surgery for Morbid Obesity. (Exhibit #2) Dr. Howard's presentation included the following points:

- In 1997, Indiana became one of three states that had an adult obesity level of 20% or greater. Currently, about 30% of Americans are obese.
- A study of the prevalence of individuals who are overweight or obese in select groups of people demonstrates that there is ethnic and racial disparity.
- Surgical procedures emerged as treatment for the severely obese. Estimated 140,000 procedures in 2004.
- The two most common bariatric surgeries are the distal Roux-en-Y gastric by-pass and the adjustable gastric band procedure. The gastric band procedure is a newer technique for which long term data is unavailable.
- Anthem's medical policy on bariatric surgery covers gastric bypass for severely obese adults who have failed conservative therapy. Patients under the age of 18 are evaluated on case by case basis.
- In 2002 Anthem had 4707 admissions for bariatric surgery (686 in Indiana). Total cost per surgery (including facility, professional and ancillary costs) can be as much as $16,000.
- 20% of bariatric surgery patients are eventually rehospitalized - with 14% being rehospitalized within 30 days.

In response to questions from the Commission, Dr. Howard stated the following:

- Anthem has not received many requests for bariatric surgery for children under 18 years of age.
- The issue of privileging surgeons is addressed by hospitals. The rate of complications decreases with the number of procedures that each surgeon performs.

Senator Miller stated that she has heard complaints from patients who felt they did not get adequate information on the risks and likely complications or proper long term followup, including adequate psychological support and long term nutritional information.

Charles Stone, M.D., Surgeon, Goshen, Indiana

Dr. Stone stated that when he was initially approached to do gastric by-pass procedures he refused. There is no place for an incidental bariatric surgery. The procedure requires a comprehensive program with ancillary services. He does not believe this procedure should be performed on a child. Dr. Stone's clinic operates under the American Society of Bariatric Surgery guidelines.

Each bariatric surgery candidate is assessed by a multidisciplinary group and evaluated on a weekly basis to determine if they would be a good candidate for bariatric surgery. There is a risk of complications and mortality but the benefits outweigh the risks. Patients should understand what the risks are and what to expect after surgery. There are other surgeries that incur more risk (e.g. colon cancer surgery) but do not receive the same attention as

bariatric surgery cases.

In response to questions by the Commission Dr. Stone stated the following:

- Physicians who perform bariatric surgery should follow established guidelines.
- Hospitals tend to be fairly strict on requiring credentialing and leery of getting involved in the procedure.
- Complications from the surgery do happen and physicians must be prepared to deal with the complications.
- Compared with the national averages the surgical center Dr. Stone works with has a lower than average complication rate.
- Dieting does not work. A Surgeon General's report in 1991 assumed that anyone can diet. As people gain weight it becomes harder to loose weight. Once a person is above a 55 body mass index (BMI) it is virtually impossible to loss weight through dieting.
- Some schools in the Goshen area are adopting the Health Generations Program to make diet and exercise changes early in students' lives.
- Bariatric surgery is the last resort for treating obesity problems.

Linda Ostermeier, RN, St. Francis Hospital, Indiana Association for Healthcare Quality

Ms. Ostermeier presented the Indiana Association for Healthcare Quality's (InAHQs) Patient Safety & Quality Initiative Proposal (Exhibit #3). The InAHQ is a non-profit association that consists of quality professionals from various health care organizations. The proposal included the following points:

- The goal is to advance collaboration in Indiana regarding dissemination of clinical practices in order to promote the enhancement of patient safety and quality care.
- Health care facilities are expected to meet requirements for improving processes and reporting outcomes but there is very little support to the facilities to meet these demands.
- When each facility has to develop the policies, procedures, forms, *et cetera* to implement a clinical best practice valuable time and resources are wasted. Having a central database with this information available to all providers saves time and health care dollars.

In response to questions by the Commission, Ms. Ostermeier stated that though certain best practice procedures are supposed to be followed by all hospitals it takes time to implement the procedures and physicians always have the final determination on the patient's course of treatment.

Senator Gary Dillon, M.D., Indiana Senate District 17

Sen. Dillon indicated reports that have documented the problems of medical errors have prompted his interest in this subject. Last year he introduced legislation to start a health care quality indicator data program. Sen. Dillon distributed a report entitled, "Spending Our Money Wisely: Improving America's health care system by investing in health care information technology". (Exhibit #4) Putting technology to work can reduce costs and cut the error rate in hospitals. A hospital in Utah has reduced its error rate by 90% after implementing an in-house computer system. Health care professionals should have the best health care information available whenever it is needed. Nobody can keep track of the drugs and proper dosages that are available on the market. Health care systems

technology can assist with proper dosage information. Most of this information is currently available. The Indiana Health Information Exchange (IHIE) is a local nonprofit company that has already started to develop and implement this technology. Sen. Dillon distributed a newspaper article on IHIE. (Exhibit #5) The state should be involved in order to help create a statewide system. The federal government wants to see health care systems technology created, so there is a possibility that the state could receive federal money to continue to develop the system.

Gregory Wilson, M.D., Commissioner, Indiana State Department of Health

Dr. Wilson stated that Indiana is poised to be a national leader in integrated health care data systems. Indiana is close to having a statewide integrated data system available through a joint public and private initiative. IHIE is considered the private sector leader. Many different groups are interested in this system being developed because of the potential for better health outcomes and lower costs. Grocery store managers have better information systems than physicians' offices and hospitals. An integrated health care data system can help physicians with chronic disease management (e.g. currently only 30% of diabetics receive the recommended annual tests and procedures). The bioterrorism surveillance network already provides pharmacy data.

Dr. J. Marc Overhage, Indiana Health Information Exchange

Dr. Overhage stated that the current health care system is fragmented. Most people see multiple health care providers every year. As the population ages patients have more chronic conditions. According to the New England Journal of Medicine only half of the patients receive appropriate follow-up care. A paperless health care system is not the objective. Most transactions are on paper. Most health care organizations invest very little in information technology (i.e. 2.2% of their annual spending), which is well below what other industries invest in data development. An integrated health care data system is a regional database where the information that is placed in the system is controlled by the patient and the health care provider. The system would collect health information from all health care providers, and would include prescription information, lab results, and radiologic images. (Exhibit #6) The system will help reduce unnecessary medical expenses and provide better management of care to patients. It is estimated that the health care savings in Central Indiana would be about $120 million annually.

In response to questions by the Commission, Mr. Overhage stated the following:

- Privacy issues are addressed. Patients and providers control what information goes into the system. The electronic system is more secure than the current paper system. There is no unique identifier of the patient - the system recognizes various identifiers in various systems.
- Hospitals and the Indiana State Department of Health currently keep data concerning infections in hospitals. The data cannot directly determine how many infections of a certain type each hospital has each year. It is difficult to determine infections that are externally acquired or due to hospital procedure.

Senator Gary Dillon, M.D., Indiana Senate District 17

Sen. Dillon presented PD 3389 which was SB 482-2004. The draft would require the

Indiana State Department of Health to develop a health care quality data program with data that has already been collected. The idea is to "glean" existing information to improve health care.

Gregory Wilson, M.D., Commissioner, Indiana State Department of Health

Dr. Wilson noted that comments by provider groups on SB 482-2004 need to be taken into consideration. Valid health indicators need to be established to provide consistent health care outcomes. It is difficult to collect a standard and uniform medical record. The issue of who controls the data involves a proprietary issue. Public health needs to have aggregated data not individual level data. With better public health data there is a savings potential.

In response to a question concerning the accuracy of information put into an integrated health care data system, Dr. Wilson stated that a lot of the data is already electronically transmitted and some office data never gets into any system.

The Chairperson then began discussions of the Commission's findings and recommendations. All votes were taken by roll call.

The Commission adopted (9-1) the finding that the Indiana State Department of Health should develop and implement a health care quality indicator data program.

PD 3401- Student Growth Information.
Requires a school corporation to report student growth information to the Indiana State Department of Health in a manner that does not make students personally identifiable. The PD was amended to provide a sunset date of 2015. The PD, as amended was adopted by a vote of 10-0.

PD 3194 - Office Based Sedation Standards.
Requires the Medical Licensing Board to adopt rules concerning office based procedures that require certain levels of sedation.

In response to a question raised by **Mark Scherer,** the Commission indicated that the requirement in the PD that the Board "refer" to the American Medical Association's Office-based Surgery Core Principles did not mean the Board was bound to or had to adopt those principles. PD 3194 was adopted 10-0.

PD 3675 - Health Care Practitioner Board Investigations.
Requires a hospital board to report a disciplinary action against a physician to the medical licensing board. Provides that a person who files a complaint against a health care practitioner concerning a health care issue waives confidentiality of the person's health care records. Allows a board that regulates a practitioner to adopt rules concerning the prosecution of complaints and petitions for review of denial of applications. Amends the standards of practice for practitioners. Allows a board to impose a fine of up to $5,000 for failing to comply with an order related to a narcotic drug. Establishes procedures for reporting a practitioner's conviction or plea to certain crimes.

Representatives of the Attorney General's Office, Health Professions Bureau, and the

Indiana State Medical Association had met on this issue but could not reach an agreement. **Jennifer Thuma** of the Attorney General's Office stated that investigations of physicians were at one time located in the Medical Licensing Board but the General Assembly moved all investigations of health care professionals to the Attorney General's Office. Objectivity of investigations might be compromised if investigations were moved back to the Board. She indicated that there were still many things that could improve the disciplinary system (e.g. increase speed of communication between the Board and the investigators, increase the use of Administrative Law Judges, and increase penalties).
Mike O'Brien of the Indiana State Medical Association (ISMA) stated the investigation process could work more efficiently but that the ISMA still supports the concept of moving investigators under the control of the Board.
Ralph Stuart, M.D. believed the Patient Safety Subcommittee's recommendations should be adopted, including placing licensing fees in a dedicated fund to be administered by the Board.
Barbara McNutt, Health Profession Bureau, stated that the ISMA's proposal of having investigators in the Medical Licensing Board but not other health care professional boards would create a bifurcated investigation system.
Doug Kinser expressed several concerns with PD 3194 (e.g. does the draft comply with federal confidentiality requirements).

After discussion by the Commission members, the Commission decided not to vote on PD 3194 but voted 8-1 to support efforts to change the investigation system to expedite the investigation of complaints.

The Commission voted 9-0 to adopt the Final Report with changes to reflect the final meeting. The Commission also requested that copies of the Subcommittee reports be attached to the final report.

The meeting was adjourned at 3:45 PM